LAST NAME_____ FIRST NAME_____ MI _____ Age_____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate:____/____/____ Soc. Sec. #: ____-____-____ Home Phone: ____-____-____ ❑ Single ❑ Married ❑ Other _____

Work Phone: ____-____-____ Cell Phone: ____-____-____ ❑ Employed ❑ Student, if student where? _____

Employer _____ Present position: _____ How long held? _____

Insurance Co. _____ Policy: _____ Group # _____ Local: _____

Do you live with both parents? ❑ Yes ❑ No ❑ Mother? ❑ Father? ❑ Guardian? Who is responsible for payment? _____

Father (or male guardian) Complete Name:_____ DOB:____/____/____ SS# ____-____-____

Home Address (if different from patient)_____ Zip _____ Home Phone: ____-____-____ Cell Phone: ____-____-____

❑ Employed ❑ Homemaker ❑ Retired ❑ Other _____ ❑ Student, If student where? _____ Local#: _____

Employed by: _____ Address/City: _____ State:_____ Zip: _____

Present position:_____ How long held? _____ Work phone: ____-____-____

Dental insurance company: _____ Group#: _____ Policy#: _____

Mother (or female guardian) Complete Name:_____ DOB:____/____/____ SS# ____-____-____

Home Address (if different from patient)_____ Zip _____ Home Phone: ____-____-____ Cell Phone: ____-____-____

❑ Employed ❑ Homemaker ❑ Retired ❑ Other _____ ❑ Student, If student where? _____ Local#: _____

Employed by: _____ Address/City: _____ State:_____ Zip: _____

Present position:_____ How long held? _____ Work phone: ____-____-____

Dental insurance company: _____ Group#: _____ Policy#: _____

Method of payment for dental care: ❑ Payment in full at each appointment. ❑ Insurance or prepaid program.

I first learned about this dental office from: ❑ Phone Book/specify: _____ ❑ Newspaper ❑ School ❑ Work

Referred by: ❑ Another patient, friend ❑ Another patient, relative ❑ Dental office doctor or staff member. ❑ Other_____

Name of person who referred us: _____ Best phone number to call about appointments: _____

DENTAL HISTORY Is this your first visit to the Dentist? ❑ Yes ❑ No Reason for todays visit _____

Have you been having any specific problems? ❑ Yes ❑ No Describe:_____

Last dental visit: _____Purpose: _____Date of last dental x-rays:_____Last complete exam: _____

Has fear of discomfort kept you from regular visits? ❑ Yes ❑ No How do you describe your dental health? ❑ Good ❑ Fair ❑ Poor

Do you think you have active dental disease: Decay? ❑ Yes ❑ No Gum Disease? ❑ Yes ❑ No

Home care: Brush? ❑ Yes ❑ No Floss? ❑ Yes ❑ No Manual or electric toothbrush? ❑ Yes ❑ No Brand:_____

Do your gums ever bleed? ❑ Yes ❑ No How often? _____ Are you troubled with bad breath? ❑ Yes ❑ No Dry Mouth? ❑ Yes ❑ No

How do you feel about ever losing your teeth? _____ Existing dental prosthetics? ❑ Yes ❑ No Year placed? _____

Have you had any unusual effects from previous dental treatment? ❑ Yes ❑ No Describe _____

MEDICAL HISTORY (Confidential, Repeated every five years.) Medical doctor's name: _____

Last physical exam: _____ Do you have any medical problems? ❑ Yes ❑ No Describe _____ Sex: ❑ M ❑ F

(Women) Are you pregnant? ❑ Yes ❑ No Expected delivery date: _____

Are you under a doctor's care now? ❑ Yes ❑ No If so, for what reason?: _____

Are you taking any medication, pills or drugs? ❑ Yes ❑ No Please list: _____

Have you ever had any of the following? Indicate YES with check mark (✓).

❑ HIV/AIDS	❑ Excessive bleeding	❑ Kidney disease	❑ Psychiatric care	❑ Typhoid fever
❑ Any heart problems	❑ Prolonged bleeding	❑ Kidney dialysis	❑ Radiation treatments	❑ Ulcer
❑ Anemia	❑ Fainting spells	❑ Low blood pressure	❑ Rheumatic fever	❑ Venereal disease
❑ Arthritis	❑ Heart murmur	❑ Malignancies	❑ Scarlet fever	❑ Osteoporosis/penia
❑ Asthma	❑ Hepatitis	❑ Measles	❑ Seizures / convulsions	❑ Allergy to medicine / drugs
❑ Circulatory problems	❑ Herpes	❑ Mitral valve prolapse	❑ Sinus problems	❑ Allergy to foods
❑ Chicken pox	❑ High blood pressure	❑ Mumps	❑ Stroke	❑ Allergy to anesthetics
❑ Diabetes	❑ Hospitalization	❑ Nervous problems	❑ Tonsillitis	❑ Other allergies
❑ Epilepsy	❑ Jaundice	❑ Prosthetic valves/joints	❑ Tuberculosis	

List all your allergies here: _____

Have you had any other serious illness? ❑ Yes ❑ No Explain:_____

Previous hospitalization or surgeries? ❑ Yes ❑ No Why:_____

Do you prefer Nitrous Oxide Sedation (tranquilizing air) during your dental treatment? ❑ Yes ❑ No I.V. Sedation? ❑ Yes ❑ No

Have you ever had difficulty with anesthetics? ❑ Yes ❑ No Explain:_____

Do you wish to talk to the doctor about any thing not listed? ❑ Yes ❑ No Comments: _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Parent Signature _____ Date: _____

AUTHORIZATION: ADULT OR EMANCIPATED MINOR: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Patient Signature _____ Date: _____

Reviewed by Doctor _____ Date: _____

I have received a copy of Family Dental Services Notice of Privacy Practices.

Patient Signature _____ Date: _____ B/P 06/14